

**Provider Profile
Vaccines for Children Program**

1. Today's Date: //

2. Employer Identification Number:

_____ M M D D Y Y Y Y

All State-approved public and private health care providers participating in the Vaccines for Children (VFC) program must complete this form. This document provides shipping information and helps the State determine the amount of vaccine to be supplied through the VFC program. This form also may be used to compare estimated vaccine needs with actual vaccine supply. The State health department must keep this record on file with the "Provider Enrollment" form. The Provider Profile form must be updated annually or more frequently if 1) the number of children being served changes, or 2) the status of the facility changes (e.g., private provider becomes an agent of a Federally Qualified Health Center).

3. Provider's Name: _____

4. Clinic Name: _____

5. Vaccine Delivery Address: _____

Street (No P.O. Boxes)

City

State

Zip

6. Days and Times Vaccine May be Delivered: _____

7. Contact Person: _____

Last

First

Title

8. Telephone Number: () _____

9. Fax Number: () _____

10. Type of Facility:

- | | |
|--|---|
| <p><input type="checkbox"/> A. Public Health Department</p> <p><input type="checkbox"/> B. Public Hospital</p> <p><input type="checkbox"/> C. Private Practice (Individual or Group)</p> <p><input type="checkbox"/> D. Private Hospital</p> | <p><input type="checkbox"/> E. Federally Qualified Health Center (FQHC)</p> <p><input type="checkbox"/> F. Rural Health Clinic (RHC)</p> <p><input type="checkbox"/> G. Other Public Facility _____</p> <p><input type="checkbox"/> H. Other Private Facility _____</p> |
|--|---|

Provider Profile

11. Vaccine Need:

Note: The following information must be based on data and not estimates. Please document the data source for this information in the boxes provided.

Part A. For the 12 mo. period beginning ____/____/____ project the number of children who will receive vaccinations at your health facility, by age group.
M M D D Y Y

<1 Year Old	1-6 Years	7-18 Years	Total
a.	b.	c.	d.

Part B. Of the total number for each age group entered above, how many children are expected to be VFC eligible, by category?

	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No health insurance				
American Indian/Alaskan Native				
Underinsured*				
Total				

* Underinsured children are only eligible through the VFC program if vaccinated at a FQHC or RHC. Only complete this row if Item 10e or 10f has been checked.

Type of data used to determine profile:

- | | |
|--|--|
| <input type="checkbox"/> A. Benchmarking Data | <input type="checkbox"/> B. Medicaid Claims Data |
| <input type="checkbox"/> C. Provider Encounter Data | <input type="checkbox"/> D. Registry Data |
| <input type="checkbox"/> E. Vaccine Replacement Data | <input type="checkbox"/> F. Doses Administered Data* |
| <input type="checkbox"/> G. Prior Ordering Data | <input type="checkbox"/> H. Other _____
(Specify) |

*Doses administered data must be converted into the numbers of children being served. States should develop formulas which convert doses of specific antigens administered into population estimates by ages. These ages should correspond to the age groups identified in the table above.

Example Formulas

<1 and 1-6 Years Old Age Group

"Every 3 doses of diphtheria containing product administered to children <1 year old is equivalent to one child. Every 4th dose of diphtheria containing product administered to a child 1-6 years of is equivalent to one child. Every 5th dose of diphtheria containing product administered to a child 1-6 years of age is equivalent to one child. Therefore, 5 doses of diphtheria containing product is equivalent to 3 children."

7-18 Years Old Age Group

"Every dose of measles containing vaccine administered to a child 7-18 years of age is equivalent to one child".